# BACKGROUND PAPER FOR HEARING

## DENTAL BOARD OF CALIFORNIA

### IDENTIFIED ISSUES, QUESTIONS FOR THE BOARD, BACKGROUND CONCERNING ISSUES, AND PRELIMINARY RECOMMENDATIONS

## PRIOR SUNSET REVIEW:

The Dental Board of California (Board) was last reviewed by the Joint Legislative Sunset Review Committee (JLSRC) four years ago (1996/97). At that time the JLSRC:

(1) Recommended that the State of California should continue to regulate (license) the practice of dentistry,
(2) Recommended that the State should continue to license all classifications (dentist, registered dental assistant, registered dental hygienist, etc.) currently licensed;
(3) Recommended that the State should not require the licensing of all dental assistants;
(4) Did not support the expansion of practice of registered dental hygienists to work without the supervision of a dentist;
(5) Recommended continuation of an independent Board rather than having it sunset and having its functions assumed by the Department of Consumer Affairs (DCA or Department);
(6) Recommended no change in the composition of the Board's membership;
(7) Recommended eliminating the Board's standing committee for dental auxiliary matters and instead recommended that the Committee on Dental Auxiliaries (COMDA) be statutorily granted the dental auxiliary examination and licensing functions it currently exercised via agreement with the Board;
(8) Recommended elimination of the Board's authority to employ sworn peace officers on its own staff to perform disciplinary investigations; and
(9) Supported reviewing the concept of "licensure by credential" in California for dentists who are licensed in another state – as was recommended by the Board at that time.

Following those recommendations the Legislature enacted SB 826 (Greene, Chapter 704-Statutes of 1997) that: extended the board's (and COMDA's) sunset date to July 1, 2002, reduced the Board's total authorized peace officer positions from 17 to 7 and authorized the Department to transfer the 10 peace officer investigators to its Division of Investigation, and statutorily codified the dental auxiliary examination and licensing functions of COMDA while eliminating the Board's own separate dental auxiliary committee. Subsequently, AB 900 (Alquist, Chapter 840-Statutes of 1997), an urgency statute sponsored by the California Union of Safety Employees, increased the Board's authorized peace officer positions from 7 to 10, and further authorized the Director of the DCA to designate an additional 7 peace officers to be assigned to the Board until July 1, 2002. AB 900 also required the Board to contract with an outside entity to conduct an independent study to examine what the board's needs are for sworn peace officer positions in its investigation unit. The bill appropriated $100,000 for the study, and required it to be completed and submitted to the Legislature by January 1, 2001.

## GENERAL BACKGROUND AND DESCRIPTION OF THE DENTAL BOARD

The statutory laws governing dental auxiliaries are located in the Dental Practice Act (DPA) - B&P Code Sections 1600-1808, specifically B&PC 1740-1770. The related administrative regulations are located at 16 Code of California Regulations (CCR) - Sections 1000-1090.1, specifically 16 CCR 1067-1090.1.

The Dental Board of California was created by the California Legislature in 1885, and was originally established to regulate dentists. Today the Board regulates the practice of approximately 74,000 dental health professionals including almost 30,000 dentists and 44,425 licensed dental auxiliaries composed of 29,868 Registered Dental Assistants (RDAs ), 13,870 Registered Dental Hygienists ((RDHs), 654 Registerd Dental Assistants in Extended Functions (RDAEFs ), 12 Registered Dental Hygienists in Extended Functions (RDHEFs), and 21 Registerd Dental Hygienists in Alternative Practice (RDHAPs). There are also an undetermined number of unlicensed dental assistants who also work in dental offices under the supervision of a licensed dentist.

The Committee on Dental Auxiliaries is a statutorily created (1974) committee within the jurisdiction of the Board. Since 1998 the Committee has statutory authority to administer dental auxiliary license examinations, issue and renew dental auxiliary licenses, evaluate auxiliary educational programs, and recommend regulatory changes regarding dental auxiliaries. The Board has the authority regarding all aspects of the licensing of dentists, all enforcement and investigation authority regarding all dental office personnel including dentists, licensed and unlicensed dental auxiliaries, and the approval of educational programs that provide the prerequisite education to become a licensed dentist or dental auxiliary.

The Board is composed of fourteen (14) members - 8 are licensed dentists, 2 are dental auxiliaries (1 RDH and 1 RDA), and 4 are public members. Two of the public members are appointed by the Legislature (one by each house) and the remaining 12 members are appointed by the Governor. The Board has an annual budget of approximately $5 ½ million.

# CURRENT SUNSET REVIEW ISSUES

## BOARD COMPOSITION ISSUES

### ISSUE #1. DO DENTISTS EXERCISE TOO MUCH CONTROL OVER THE DENTAL BOARD'S LICENSING AND REGULATION OF THEIR PROFESSION AND THE PRACTICES OF DENTAL AUXILIARIES?

**QUESTIONS FOR ISSUE #1 FOR THE BOARD:**

- *Should the composition of this board be changed to decrease or eliminate the outright control of this public agency by its licensed dentists who constitute an 8 member majority of the 14 member board?*

- *If the dentist majority control were to be reduced or eliminated, should public members or licensed auxiliary members be added to the board in place of some of its dentist members, or should the board's size be increased to add public members or licensed dental auxiliaries?*

- *If the expertise of dentists (or dental auxiliaries) is needed to administer the state's licensing and regulation of the dental and dental auxiliary professions – couldn't that be obtained by hiring or contracting for services in the same manner as the board obtains license exam examiners (assuming the necessary statutory authority existed)?*

- *Alternatively, should the Committee on Dental Auxiliaries (COMDA) be made into a separate, independent licensing board for dental auxiliaries with all of the related state licensing authority? If not, should COMDA, as a committee within the jurisdiction of the Dental Board be given the enforcement authority to discipline dental auxiliaries?*

- *Should the scope of practice (authorized duties) of dental auxiliaries be moved from board regulations into statute, as would have been provided for by SB 1215 (Perata – 1999/2000), rather than having them in board regulations?*

**BACKGROUND:** The Board is composed of fourteen (14) members - 8 are licensed dentists, 2 are dental auxiliaries (1 RDH and 1 RDA), and 4 are public members. Two of the public members are appointed by the Legislature (one by each house) and the remaining 12 members are appointed by the Governor. With 8 members constituting a quorum for the conduct of business, even 5 of the dentist members of the Board could control the outcome of any decisions. Thus decisions by the Dental Board could be made without the assent of any of the public members or the two dental auxiliary members.

The scope of practice for the various dental auxiliaries are essentially defined by this dentist dominated board through its adoption of regulations that determine what duties are delegated to the various categories of dental auxiliaries and under what level of supervision – general or direct. For years the dental auxiliaries have chafed under this dominant control over their allowable duties by the dental majority on the board. This has led to a number of bills introduced over the years calling for the creation of a licensing board for all dental auxiliaries separate and independent from the Dental Board. That legislation would provide for that separate board to perform all of the licensing and disciplinary functions related to the licensing of dental auxiliaries, and for the various scopes of authorized dental practices of each classification of auxiliary to be codified in statute rather than being promulgated by Dental Board regulation. The most recent bill was SB 1215 (Perata) which was introduced last Session but was held in the Senate Business and Professions Committee pending a review of the issues by the JLSRC during the Board's and COMDA's sunset reviews.

While many of the state occupational licensing boards within the Department of Consumer Affairs have public member majorities, those related to the professional health occupations have licensee majorities. Whether such dominance over their own state regulation (i.e., "the fox guarding the hen house") is necessary to assure that licensee expertise regarding the profession is satisfactorily reflected in a licensing board's decisions is debatable. In particular, the dental auxiliaries point to the long history of the board's restrictive actions with respect to increasing the duties authorized for Registered Dental Assistants and Registered Dental Hygienists as one significant indication that the dentist majority controls state licensing primarily for its own benefit and not in a manner that maximizes the ability of dental auxiliaries to provide services to more members of the public. Further, the dental

auxiliaries point out that even when the Legilislature enacts legislation that increases the authority of dental auxiliaries to perform their services (AB 560) the board exhibits a resistance to and delays implementing those legislative changes.

If the dentist dominance of the states licensing board which regulates the practice of dentistry is believed to be too great it could be moderated by reducing the number of dentists in favor of increasing public and dental auxiliary representation so that the views of the public must be taken more into account in the Board's decision-making. Another approach with respect to dominance over the practices of dental auxiliaries could be to provide for a separate board for their regulation. It should be kept in mind that the practice of dentistry is considered to encompass the duties performed by dental auxiliaries and that those auxiliaries, except for the new RDHAP classification, are required to perform all of their dental duties or services under the supervision (general or direct) of a licensed dentist. Thus the licensed dentist is viewed to be ultimately in charge of, and liable for, the practice of dentistry in a dental facility.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## LICENSING ISSUES

### ISSUE #2. SOME DENTISTS, NOTABLY ORAL AND MAXILLOFACIAL SURGEONS SOME OF WHOM ARE LICENSED ONLY AS DENTISTS AND NOT AS PHYSICIANS, HAVE ILLEGALLY BEEN PERFORMING SURGICAL PROCEDURES THAT ARE STRICTLY COSMETIC IN NATURE SUCH AS FACE LIFTS, WRINKLE REMOVAL, AND EYE LID PROCEDURES.

**QUESTION #2 FOR THE BOARD:** *What is the board's position on the performance of cosmetic procedures by persons licensed only as dentists? What actions has the board taken since November 10, 1999 to stop licensed dentists from performing illegal cosmetic procedures? (Please provide copies of any written materials the board has issued since that date.) What efforts has the board taken to ascertain whether cosmetic surgical procedures are being performed by persons licensed only as dentists, rather than simply waiting to receive complaints? What actions has the board taken when it has evidence that a licensed dentist is conducting illegal cosmetic surgery? What is the board's current position on specialty licensure?*

**BACKGROUND:** The Business and Professions Committee held an informational hearing on the issue of cosmetic surgery in early 1999 because of increasing concerns over the safety of patients undergoing these surgical procedures. The hearing came about as a result of reports of severe injury and deaths that had occurred to patients. The type of cosmetic surgery involved was elective surgery performed solely to enhance the patient's appearance rather than to correct for trauma or abnormal deformity. Such surgeries are frequently performed in outpatient (non-hospital) settings by a physicians from a variety of medical specialties. Because of the concerns over patient safety, legislation was introduced that same year to specify the type of medical training that would be required to perform such surgery and to require that the surgery be performed in regulated outpatient or licensed medical facilities.

One of the concerns that surfaced was regarding the illegal performance of cosmetic surgery by persons holding only a dental license but not a medical license – oral and maxillofacial surgeons.

Senator Figueroa made informal inquiries regarding this to the Dental Board and was assured that the Board was in agreement with the Medical Board, the Attorney General, legal counsel for the Department of Consumer Affairs, and others who had concluded that dental licensees could not legally perform cosmetic surgery without having a medical license issued by the Medical Board. Despite this assurance, it became apparent that dental licensees were openly and illegally advertising and performing cosmetic surgery.

On November 10, 1999 Senator Figueroa formally demanded that the Dental Board perform its duty and take steps to curb these illegal surgeries. Following that demand the Board, on January 24, 2000, sent out an advisory letter to oral and maxillofacial surgeons holding only a dental license to restrict their surgical treatment to cases where cosmetic procedures are part of the treatment for a dental condition such as facial trauma or congenital maxillofacial anomalies.

Despite these efforts these illegal practices appear to be continuing – as evidenced by a recent case reported in the media concerning severe burn injuries to a patient undergoing purely cosmetic facial surgery performed by a person licensed only as a dentist. Consequently the issue of illegal practice of cosmetic surgery by dental licensees still appears to confront the Board.

During the last sunset review of the Dental Board the Department of Consumer Affairs did not support specialty licensure for classifications of dentists. The Board has been involved in considering the issue of specialty licensure and has, at least at one time, had an ad hoc committee studying the disparity between oral surgeons' education and training and the current scope of dental practice by which their practice is governed. Specialty licensure to establish a new license classification or classifications must go through a "sunrise" process specified in state statute that involves providing detailed responses to a questionnaire to ascertain whether such new licensing is necessary to protect the public.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #3. REQUIRING EDUCATIONAL PROGRAMS FOR "EXTENDED FUNCTIONS" (RDAEF OR RDHEF) OR FOR ALTERNATIVE HYGIENE PRACTICE (RDHAP) TO BE AFFILIATED WITH A DENTAL SCHOOL FOR BOARD APPROVAL MAY UNNECESSARILY LIMIT OR PREVENT SUCH PROGRAMS FROM BEING OFFERED

**QUESTION #3 FOR THE BOARD:** *Why is affiliation with a dental school necessary for RDAEF, RDHEF or RDHAP educational programs when RDA and RDH educational programs that include both classroom education and clinical training can be approved without such affiliation? [ Correction note: Dental school affiliation is required for RDA educational programs but not for RDH educational programs. Both include didactic and clinical coursework.] Why shouldn't that requirement be considered to be simply a means for restricting the availability of those programs and the number of related licensees – particularly in light of the controversy and long delay in the board's adoption of regulations to implement AB 560's licensing of RDHAPs? If delegating as many dental service functions as possible (under general or direct dentist supervision) to dental auxiliaries can increase the availability and reduce the cost of those services to the public, shouldn't increasing the availability of the necessary dental auxiliary training programs be a priority?*

**BACKGROUND:** AB 560 (Perata, Chapter 753-Statutes of 1997), sponsored by the California Dental Hygienists Association (CDHA), enacted licensing for a new category of dental auxiliary called a Registered Hygienist in Alternative Practice (RDHAP). An RDHAP is authorized to provide some dental hygiene services in specified settings (residences of the homebound, schools, residential facilities, and dental health professional shortage areas) independently and without supervision of a dentist, so long as those services are provided pursuant to a prescription of a licensed dentist or physician. That bill was an outgrowth of two Health Manpower Pilot Projects (HMPPs) in which hygienist who had taken additional educational courses at California State University at Northridge, unaffiliated with a dental school performed for several years in a similar independent manner. Under AB 560, to become a RDHAP, a RDH must take an additional 150 hours of educational courses prescribed by regulations adopted by the Dental Board. That required education is didactic as was the prerequisite HMPP educational program, rather than being clinical. (The clinical training would appear to be satisfied by another prerequisite that an applicant for an RDHAP license must have at least 2,000 hours of actual clinical hygiene practice in the preceding 36 months.)

Despite the precedent of the HMPP, the board adopted the requirement that to obtain board approval, all RDHAP educational programs must be affiliated with an approved dental school. This precludes an approval for an unaffiliated program such as that used for the HMPP and, to date, no RDHAP programs exist. As a result only those RDHs (21 in total) who participated in the last HMPP (No.155) and were "grandfathered" into meeting prerequisite education have become licensed as RDHAPs. The California Dental Hygienists Association's sunset report points out that this requirement creates two problems in particular. One problem is the lack of accessibility for applicants who reside in areas that are distant from a dental school. The second problem is the lack of schools affiliated with dental schools to offer a RDHAP program. CDHA believes that given the board's record of resistance, restriction, and delay in implementing the RDHAP licensing category, and the lack of an apparent need for RDHAP didactic educational programs to be affiliated with a dental school, the board has imposed unreasonable roadblocks to growth in the RDHAP licensee population. The same requirement for dental school affiliation exists to obtain approval for RDAEF and RDHEF **e**ducational programs.

Even without the dental school affiliation requirement, the Board retains the authority to specify course content and other components to assure that a RDHAP or/and EF program is providing the necessary instruction for producing competent licensees. Unnecessary restrictions imposed on these programs would seem to impose burdens that could reduce, eliminate, or prohibit the availability of such programs and reduce the number of persons who will ultimately be licensed to provide services to the public.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #4. SHOULD THE BOARD REQUIRE DENTISTS TO PROVIDE THE BOARD'S DENTAL MATERIALS FACT SHEET TO ANY PATIENT WHO REQUIRES A RESTORATION (CAVITY FILLILING), AND SHOULD DENTISTS BE REQUIRED TO ADVISE THEIR PATIENTS REGARDING THE DIFFERENT TYPES OF RESTORATIVE FILLING MATERIALS, THAT AMALGAM FILLINGS CONTAIN 50% MERCURY WHICH IS CONSIDERED A HAZARDOUS SUBSTANCE, AND DISCLOSE THE HEALTH RISKS OF MERCURY TO PATIENTS AND DENTAL OFFICE EMPLOYEES WHO WORK WITH DENTAL AMALGAM?

**QUESTION #4 FOR THE BOARD:** *When will the "Dental Materials Fact Sheet," required by legislation enacted in 1993, be completed and made available? Does the board plan to make the fact sheet available only to dentists or will it also be making it available to patients and the general public – for example upon their request or placed on the board's Internet website?*

**BACKGROUND:** This issue was raised by Consumers for Dental Choice (CDC).

Dental amalgam for filling cavities contain approximately 50% mercury; other restorative materials include gold and composite resin. Mercury is a toxic metal and concerns have been raised that the mercury in dental amalgam can escape from a filling and pose a health risk to the dental patient. There have been a number of studies performed over the years without any consensus as to the danger of dental amalgam. However, some of those studies indicate the mercury can pose a hazard particularly to pregnant women. The government of Canada and some amalgam manufacturers have warned that dental amalgam should not be used with pregnant women, young children, or persons with mercury allergies. CDC states that since the Board has indicated in its newsletter that mercury has "reproductive toxicity" that the Board should go further and warn against the use of amalgam in pregnant women and children.

Legislation enacted in 1992 required the Board to develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect (e.g., filling cavities). The fact sheet was to describe the available materials, compare their relative benefits and detriments, compare their costs, and encourage discussion between the patient and the dentist regarding the materials and the patient's options. The fact sheet was to be made available to all licensed dentists and the Board is required to update the fact sheet as necessary.

The Board developed a two-page fact sheet in May of 1993 but it received very little circulation. CDC petitioned the Board in 1999 to revise the fact sheet to rid it of misleading language regarding amalgams, include all of the statutory language regarding the dentist's responsibility to fully inform his or her patient of the available options, encourage dentists to discuss the advantages and disadvantages of the available material, cover the past six years of research documenting hazards of all dental materials, and provide dentists guidance on properly warning patients about the reproductive toxicity of the mercury contained in dental amalgam. CDC also believes that the fact sheet should address ways in which dentists can determine patient sensitivity to mercury. Dentists should advise their patients that amalgam contains mercury which is a substance designated as toxic under Proposition 65, and that dentists should provide copies of the revised fact sheet to any patient requiring a dental restoration.

The board is currently in the process of revising the fact sheet but indicates that it does not have the authority to require dentists to provide it to their patients nor require that they discuss the choice of restorative materials with their patients.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #5. SHOULD THE BOARD PERMIT REGISTERED DENTAL HYGIENISTS TO SUBGINGIVALLY (BELOW THE GUMLINE) PLACE ANTIMICROBIAL AND ANTIBIOTIC MEDICATIONS SUCH AS DISSOLVING FIBERS?

**QUESTION #5 FOR THE BOARD:** *What rationale supports the board's past decisions not to permit registered dental hygienists to place these medications – given their approval by the federal Food and Drug Administration (FDA), the capability of RDHs to perform this function, and the authority for dentists to place these medications? Why hasn't the board reevaluated this issue this past year upon the conclusion of the one-year moratorium it prescribed when it last rejected permitting hygienists to perform this function? When will this issue be taken up for a decision by the board?*

**BACKGROUND:** According to the California Dental Hygienists Association (CDHA), since 1994 the Board has repeatedly rejected its requests for a regulatory change that would authorize RDHs to place and remove antibiotic fibers that are used as an adjunct to root planing and scaling for the treatment of early periodontal disease. This year's CDHA sunset review report points out that RDHs in 33 other states are allowed to perform this procedure, that research has been done supporting the use of these products by RDHs, and that there is an absence of evidence showing consumer harm.

COMDA also has recommended this regulatory change to the Board in 1996 and 1999, but both times it was rejected. According to COMDA, this recommendation was made after extensive occupational analysis of RDH practice, meetings, and hearings. The Board's summary of reasons issued in July of 1999, cited the newness of the products being considered, potential harm to the public, and that the public is better served by allowing only dentists to perform these procedures and any necessary follow-up care. The Board also stated it believed that the issue should be re-evaluated in one year. However, that Board did not vote on the issue but instead voted to hold an informational hearing. The board's vote on this issue will now come up at next March's Board meeting nearly two years later.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #6. INDEPENDENT PRACTICE ASSOCIATIONS (IPAS) AND DENTAL MANAGEMENT SERVICE ORGANIZATIONS (DMSOS) ARE OPERATING WITHOUT BEING REGULATED AND MAY CREATE A LACK OF ACCOUNTABILITY IN THE PROVISION OF DENTAL SERVICES.

**QUESTION #6 FOR THE BOARD:** *Why does the Board believe that IPAs and DMSOs operating in California provide dental services without accountability? How do those entities provide dental services? How many of these entities are operating in California and what is the estimated percentage of dental services they provide? Who is the board meeting with in the managed care industry to develop an approach to correct the perceived lack of accountability? What is the status of the board's discussions with the managed care industry? Is it likely that the board will seek authority to formally regulate these entities?*

**BACKGROUND:** This issue was raised in the Board's Sunset Report. The Board appointed and ad hoc committee on April 21, 1999 to study the subjects of independent practice associations (IPAs) and

dental management service organizations (DMSOs). The board states that it is aware that there are DMSOs operating within California that are not regulated by wither the Board nor by the State Department of Managed Health Care. The Board believes that this situation creates a subcategory of dental service operating without accountability, and states that Board staff have been meeting with representatives of the managed health care industry in an attempt to define an approach to correcting the situation. The Board has not indicated that such an approach has been yet defined nor the specific nature of the problems and their magnitude. Last Session, AB 2332 (Mazzoni) was introduced and would have required DMSO's to be licensed by the Department of Managed Health Care as a health care service plan. That bill died in its first policy committee.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #7. SHOULD THE BOARD LIMIT DENTISTS TO GIVING GENERAL ANESTHESIA AND CONSCIOUS SEDATION TO CHILDREN IN HOSPITALS, AND PROHIBIT ETHER PROCEDURE IN STAND-ALONE DENTAL OFFICES WHEN THERE IS NO ANESTHESIOLOGIST PRESENT?

**QUESTION #7 FOR THE BOARD:** *How many deaths or injuries have occurred as a result of the performance of these two procedures in dental offices over the past few years? How many involved children? How many occurred where no licensed anesthesiologist was present?*

**BACKGROUND:** This issue was presented by Consumers for Dental Choice (CDC). CDC. The Dental Practice Act currently prohibits any dentist from administering oral conscious sedation on an outpatient basis to a patient under 13 years of age unless the dentist meets specified licensing and permit requirements. In addition to having a dental license, the dentist must obtain either a general anesthesia permit or a conscious sedation permit from the Board. To obtain such a permit the dentist must show that he or she has taken additional education regarding oral sedation and/or anesthesia. The law also requires that the dentist must be physically present in the treatment facility when oral sedation is being administered and that the dental office meet certain facility and equipment requirements specified by the board in regulation. The dental office is also subject to Board inspection both initially prior to the issuance of a permit and later on a continuing basis.

Current law also permits a physician, until January 1, 2002, to administer general anesthesia in a dental office, whether or not the dentist has been certified to administer general anesthesia, if the physician holds a valid general anesthesia permit issued by the Dental Board.

Consumers for Dental Choice argue that performance of oral conscious sedation by a dentist in the outpatient setting (dental office) is too risky and that a tragic number of deaths have occurred as a result of this practice. CDC argues that performance of either procedure on a child should either be done with a licensed physician anesthesiologist present or in a licensed hospital setting where there is a sophisticated emergency back-up system in place.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #8. SHOULD EDUCATION IN INFECTION CONTROL, CARDIO PULMONARY RESUSCITATION (CPR) AND DENTAL JURISPRUDENCE BE REQUIRED ON AN ONGOING BASIS RATHER THAN JUST ONCE, AND SHOULD IT BE REQUIRED OF UNLICENSED DENTAL ASSISTANTS RATHER THAN JUST LICENSED DENTAL ASSISTANTS AND LICENSED DENTAL HYGIENISTS.

**QUESTION #8 FOR THE BOARD:** *What requirements does the board currently have for education in these subjects, and to whom do they apply? Do they apply to unlicensed dental assistants, who also work on patients in a dental office? If not, why not? Why did the board not require ongoing education in theses subjects?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #9. SHOULD THE BOARD PROHIBIT UNLICENSED DENTAL ASSISTANTS FROM PERFORMING ANY AND ALL INTRA-ORAL (IN THE MOUTH) INVASIVE PROCEDURES, AND REQUIRING THAT THEY BE PERFORMED BY LICENSED DENTISTS AND AUXILIARIES WHO HAVE DEMONSTRATED MINIMUM COMPETENCY BY OBTAINING SPECIFIED EDUCATION AND TRAINING, AND PASSED A LICENSE EXAMINATION?

**QUESTION #9 FOR THE BOARD:** *Would such a restriction essentially eliminate the on-the-job training track to licensure as an RDA and leave only the method whereby an applicant must have completed approximately 8 months in a formal, Board-approved RDA training program?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #10. IS THERE A NEED TO RE-ENGINEER THE "CAREER LADDER" FOR DENTAL AUXILIARIES AND EXPAND THE UTILIZATION OF DENTAL AUXILIARIES?

**QUESTION #10 FOR THE BOARD:** *In the face of assertions that dental auxiliaries who seek higher levels of licensure are not given credit for dental courses they have already taken, could the law be modified to specifically require that such credit be granted when the coursework required for the higher level position is equivalent to what the applicant has already successfully completed?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #11. SHOULD ALL DENTAL ASSISTANTS BE REQUIRED TO BE LICENSED, OR AT A MINIMUM, SHOULD ALL DENTAL PERSONNEL, INCLUDING UNLICENSED DENTAL ASSISTANTS, BE REQUIRED TO HAVE SOME MINIMUM EDUCATION RELEVANT TO PERFORMING DENTAL SERVICES?

**QUESTION #11 FOR THE BOARD:** *Is there a significant potential for patient harm from services being provided by unlicensed dental assistants who have no prior dental education or training?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## EXAMINATION ISSUES

### ISSUE #12. SHOULD DENTISTS LICENSED BY OTHER JURISDICTIONS (STATES OR COUNTRIES) WITH EQUIVALENT EDUCATION, TRAINING AND EXAMINATION REQUIREMENTS BE PERMITTED TO OBTAIN A LICENSE IN CALIFORNIA BY "CREDENTIAL" AND WITHOUT HAVING TO TAKE CALIFORNIA'S LICENSE EXAM?

**QUESTION #12 FOR THE BOARD:** *Given that the purpose of licensing by credential was to simplify the California licensing of practicing out-of-state dentists who possess equivalent training and already have passed an equivalent license exam – why did the lack of reciprocity by other states with regard to California's licensees who are graduates of non-accredited dental schools cause the board to not go forward with this method of licensing?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ENFORCEMENT ISSUES

### ISSUE #13. THERE HAS BEEN A SIGNIFICANT INCREASE IN THE AVERAGE LENGTH OF TIME BETWEEN TRANSMITTAL OF AN INVESTIGATION TO THE ATTORNEY GENERAL'S OFFICE AND THE SUBSEQUENT FILING OF A DISCIPLINARY ACCUSATION. THERE HAS ALSO BEEN A SIGNIFICANT INCREASE IN THE AVERAGE LENGTH OF TIME TO CONCLUDE A DISCIPLINARY CASE AFTER AN ACCUSATION HAS BEEN FILED

**QUESTION #13 FOR THE BOARD:** *What actions has the board taken or what actions is the board planning to take in the future to determine what is causing these delays in disciplinary enforcement and reducing these increased timeframes?*

**BACKGROUND:** The Board's sunset report shows that the time from completion of a Board investigation to the filing of an accusation by the Attorney General has increased from an average of 145 days to 370 days in the past year.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #14. THERE APPEARS TO BE A SIGNIFICANT REDUCTION IN THE NUMBER OF CASE CLOSURES FOLLOWING AN INVESTIGATION WHILE THE AVERAGE COST PER CASE HAS INCREASED SIGNIFICANTLY.

**QUESTION #14 FOR THE BOARD:** *Why has there been a reduction in case closures and an increase in average costs? Is this trend expected to continue and if so, what actions will the board take to improve the situation?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #15. THE AMOUNT OF RESTITUTION MADE TO CONSUMERS DECREASED SIGNIFICANTLY DURING FISCAL YEAR 1999-2000.

**QUESTION #15 FOR THE BOARD:** *Why has the amount of restitution gone down? In what kinds of cases does the board seek restitution for the consumer? Is there any indication that restitution levels will continue to decrease or remain lower than in previous years?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #16. SHOULD THERE BE ANY CHANGE IN THE AUTHORITY OF THE BOARD TO HIRE ITS OWN SWORN PEACE OFFICERS TO CONDUCT INVESTIGATIONS?

**QUESTION #16 FOR THE BOARD:** *What are the results of the independent study on the issue of the board's need to employ sworn peace officers provided for by AB 900 (Alquist, Chapter 840-Statutes of 1999)? How many sworn peace officers does the board currently employ? How many non-sworn investigators or inspectors does the board employ? What circumstances are different today than four years ago when the Joint Committee recommended elimination of the board's authority to employ sworn peace officers to perform administrative investigations?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## ISSUE #17. THERE IS AT LEAST AN ECONOMIC INCENTIVE FOR DENTISTS TO DELEGATE AS MANY DENTAL DUTIES AS POSSIBLE TO THEIR SUPERVISED DENTAL AUXILIARIES. THERE IS ALSO SOME EVIDENCE THAT DENTISTS ARE ILLEGALLY DELEGATING MORE DENTAL DUTIES TO VARIOUS DENTAL AUXILIARIES, PARTICULARLY UNLICENSED DENTAL ASSISTANTS, THAN ARE CURRENTLY PERMITTED BY LAW (BOARD REGULATION), AND THAT THOSE DENTAL AUXILIARIES ARE ILLEGALLY PERFORMING THOSE DELEGATED DUTIES.

**QUESTION #17 FOR THE BOARD:** *What efforts has the board taken in the past and what actions will it take in the future to eliminate the illegal delegation and performance of dental tasks by dental*

*auxiliaries who are not authorized by law to provide them? How feasible is it for the board to ascertain the existence of such violations? Would providing the board with the authority to conduct random inspections of dental offices be helpful? Would posting the authorized duties of the various dental auxiliaries so that dental patients could review them be helpful in curtailing the illegal delegation and performance of these duties. Would expanding the delegated dental duties that dental auxiliaries are competent and authorized to perform alleviate problems of illegal delegation and increase the quality of those services and the safety of the patient?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

**ISSUE #18. SHOULD THE DENTAL BOARD DESIGNATE A SPECIFIC ENFORCEMENT OFFICER TO HANDLE (CONCENTRATE ON) ENFORCEMENT ACTIVITIES RELATED TO THE PERFORMANCE OF DERVICES BY DENTAL AUXILIARIES?**

**QUESTION #18 FOR THE BOARD:** *Why did the board reject COMDA's recommendation to fund a specific enforcement position to handle dental auxiliary disciplinary investigations? How does the board treat violations of law, particularly with regard to their performance of unauthorized duties, when their performance is directed and supervised by their dentist employer?*

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***

## CONSUMER OUTREACH AND EDUCATION

**ISSUE #19. THE RESULTS OF THE BOARD'S CONSUMER SATISFACTION SURVEY SHOW A HIGH DEGREE OF DISSATISFACTION WITH THE BOARD'S PERFORMANCE - ESPECIALLY ITS PERFORMANCE IN COMMUNICATING ITS EXISTENCE AND HOW TO FILE A COMPLAINT WITH THE BOARD, AND IN HOW THE BOARD TREATED COMPLAINANTS AND HANDLED THEIR COMPLAINTS DURING ITS INITIAL CONTACT WITH THEM.**

**QUESTION #19 FOR THE BOARD:** *What specific actions has the board taken or what actions will it take in the future to respond to complainant dissatisfaction? Does the board list itself, its address, email address or telephone number(s) in all of the telephone books in California? Should the board be required to improve its telephone system to enable complainants to speak to a live person when calling the board's complaint unit? What information is currently available to consumer on the board's Internet website and when will the board be making improvements to its website to be more interactive and provide information on consumer options, functions and duties of the board, the board's complaint process (including the ability to file a complaint form electronically), etc.?*

**BACKGROUND:** As part of the Board's sunset review it was required to conduct a Consumer Satisfaction Survey to assess the public's level of satisfaction with the services of the Board. The Board conducted the survey of 1200 persons 10% of the 12,000 complainants who filed complaints with the Board over the past four years. The Board reports that consumers indicated disapproval of two of the seven items covered in the survey – the Board's performance in communicating its existence to the general public, and the Board's ability to satisfy consumers during their initial contact

with the Board. However, even with respect to the remaining five questions there was significant consumer dissatisfaction, especially if one considers a consumer response of "Somewhat satisfied" as also reflecting some dissatisfaction. If so, then the responses to the remaining five items that the Board's report does not focus on reflects consumer dissatisfaction running from 35 – 49%. It seems the Board should be making efforts to improve its performance relative to all seven areas, especially focusing on the two it noted in its sunset report.

**PRELIMINARY RECOMMENDATION:** ***No recommendation at this time.***